AN INVESTIGATIVE ACCOUNT · INDIAN HEALTHCARE

CURE *or* COMMERCE?

The Truth of Indian Healthcare — Seen Through Seven Eyes

PAIN · COMMERCE · TESTIMONY · RURALINDIA · THE ROOTS · RESISTANCE

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CHAPTER 01

Ramu Kaka's Fifty Thousand

Ramu was fifty-three. He worked on someone else's farm in a village forty kilometers from the nearest city. He earned ₹8,000 a month — less in the monsoon, more during harvest. He had three children, all in school. His wife kept chickens and sold eggs. He had never spent a night in a hospital. Then his stomach stopped working the way it should.

For three weeks, his wife gave him turmeric and warm water. The pain stayed. On the twenty- second day, they borrowed ₹500 from a neighbour and went to the village quack — the man everyone called "Doctor" because he sold injections and had a stethoscope and a worn copy of a medical handbook.

The quack examined Ramu's belly by pressing it in random places. "Inflammation," he said. He gave three injections over three days: the first yellow, the second clear, the third whitish. Cost: ₹300. The pain got worse.

On the twenty-eighth day, Ramu's daughter — who worked in the city as a domestic help — came home for her monthly visit. She took one look at Ramu and cried. "We have to go to the hospital," she said.

They went to the nearest government hospital, thirty kilometers away. Ramu's brother lent them his motorcycle. The ride took ninety minutes. At the government hospital, the doctor — a woman, young, tired — examined Ramu. She said: "We need an ultrasound. Our machine is broken today. Can you come back tomorrow?" It was already late, they went to a private diagnostic centre in town.

Ultrasound at the private centre: ₹800. The radiologist — a man in his fifties with thick glasses — studied the screen for three minutes. "You have gallstones," he said. "Big ones. You need a CT scan to see if the bile duct is blocked." Ramu asked: "Is the CT scan necessary?" "It's better to be sure," the radiologist said. CT scan: ₹3,500. The CT images showed gallstones, nothing more. But the radiologist said: "You should see a specialist. There's a surgeon who comes to our clinic on Wednesdays." Specialist consultation: ₹500.

The specialist — a surgeon with a nameplate that said "MS, FICS" — looked at the CT images for two minutes. "These stones are large. We should operate before they cause infection or pancreatitis. The sooner, the better." Ramu's daughter asked: "How much will the operation cost?" The surgeon said: "Depends on the hospital. Government hospital, maybe ₹8,000–12,000. Private hospital, ₹30,000–50,000. But private is safer. Better equipment, better nurses, better post-operative care."

Ramu's daughter borrowed ₹30,000 from her employer against future salary. Her uncle lent ₹15,000. Her mother-in-law borrowed from a moneylender at 18% annual interest. Total: ₹50,000. They chose the private hospital — the one with the shiny lobby, the security guard, the air conditioning that worked even at night.

— Inside the Private Hospital

They arrived at 8 AM. By 10 AM, Ramu had: registered (₹2,000 "admission fee"), met the surgeon (8-minute consultation, ₹1,500), met the anaesthetist (5-minute consultation, ₹1,000), had pre-operative blood tests done (₹1,200: CBC, blood group, coagulation profile, liver function, kidney function), had an ECG done (₹400), a chest X-ray (₹300), and a urine test (₹100). Total for admission: ₹6,500. The surgeon said the operation would be at 2 PM. Ramu was told not to eat or drink after midnight.

At 1:30 PM, a nurse came and gave him an injection. Ramu felt drowsy. He was wheeled to the operation theatre. He woke up in a recovery room at 4 PM. The pain was intense. A nurse gave him an injection for pain. He was moved to a hospital bed in the post-operative ward.

On Day 2, at 6 PM, a nurse came and said: "The doctor wants to keep you in ICU for the night for monitoring. Just precaution." Ramu asked: "Is it necessary?" "It's safer," the nurse said. He was moved to the ICU. On Day 3, the surgeon came for 2 minutes. "You can go home tomorrow.
Keep the wound dry. Take antibiotics for 5 days." Ramu asked: "Can I go home today?" The surgeon said: "Better to rest one more night. The wound is fresh." On the morning of Day 4, Ramu was given a bill. He had expected something around ₹40,000. The bill was ₹54,800.

ITEM	COST
Admission fee	₹2,000
Pre-operative tests	₹2,000
Surgeon's fee	₹8,000
Anaesthesia fee	₹3,500
Operation theatre (laparoscopic cholecystectomy)	₹12,000

ITEM	COST
Hospital bed (3 days × ₹2,000)	₹6,000
ICU bed (1 night)	₹5,000
Medications (pain relief, antibiotics, anti-nausea)	₹5,100
Nursing care	₹3,200
Oxygen and monitoring	₹2,200
Wound dressing	₹400
Discharge fee	₹800
Miscellaneous	₹4,600
Total	**₹57,800**

Ramu's daughter paid ₹30,000 from what they'd borrowed. The hospital agreed to credit the remaining ₹27,800 to be paid in monthly installments of ₹5,000. With interest from the moneylender, the total debt would be about ₹65,000 by the time it was fully paid.

— Where Did the Money Go?

The pre-operative tests billed at ₹2,000 cost the hospital perhaps ₹300–400 to actually perform. Blood tube, label, transport: ₹20. Lab technician time: ₹50. Testing reagents: ₹150. Machine maintenance amortized: ₹50. Hospital's margin: 400–500%. But here's what Ramu didn't know: the hospital laboratory was not accredited by NABL. The tests were done by a technician with minimal training. The machines had never been calibrated in the past six months.

The surgeon spent 45 minutes in the operation theatre. Active surgery was maybe 20 minutes — the rest was waiting for the anaesthetist, instruments, positioning. The anaesthetist was present for 60 minutes at ₹58 per minute. Ramu was unconscious. He couldn't refuse the fee, couldn't negotiate, couldn't shop around.

The medications billed at ₹5,100: actual pharmaceutical cost was approximately ₹270. Antibiotics (3 days): ₹80. Pain medication (3 doses): ₹40. Anti-nausea: ₹30. Anti-acid: ₹20. Injectables during surgery: ₹100. Markup: **1,788%**. The hospital buys antibiotics in bulk at ₹80 per course and sells them for ₹800.

The ICU admission was not medically indicated. Post-operative complications are rare after a straightforward laparoscopic cholecystectomy in a healthy 53-year-old. The risk of serious complications is less than 1%. Admitting to ICU "for precaution" increases the bill by ₹5,000 — and most patients won't object because they're scared and don't understand.

— What Ramu Didn't Know

He could have had this operation at the government hospital for ₹8,000–10,000. The surgeon would have been equally qualified. The outcome would have been identical. He paid ₹50,000 extra for comfort, speed, and a sense of safety. He paid for brand value, not for medical value.

He signed a blank consent form. The form said: "I consent to the operation and any other procedures the surgeon deems necessary." This allowed the surgeon to do additional procedures without explicit permission. If Ramu had been a woman, this blank consent could have allowed an "incidental" hysterectomy.

The surgeon had sent Ramu to the specific diagnostic centre for imaging. Later, it became known that the surgeon had a referral arrangement with this centre — typically 30–40% of the diagnostic cost goes back to the surgeon. The surgeon earned approximately ₹1,300–1,600 just for referring Ramu to imaging. This was not disclosed to Ramu.

Under Indian law, a patient has the right to informed consent specific to the procedure, an itemized bill before discharge, a second opinion, refusal of treatment, access to medical records, and complaint redressal. Ramu exercised zero of these, because he didn't know they existed, he was scared and in pain, he trusted the doctor completely, and he was culturally conditioned to accept the doctor's word as final.

THE ARITHMETIC OF EXPLOITATION

₹57,80

₹23,00

160%
margin
Profit on one sick farmer

₹12cr
per year
From this one procedure type alone, one hospital

CHAPTER 02

The Mother's Belly, the Doctor's Profit

Priya was twenty-eight. This was her first baby. She was terrified — not of pain, but of the hospital, of doctors, of anything going wrong. Her mother had given birth three times naturally, at home, with a traditional midwife. But Priya's husband, Vikram, wanted the "best" for his wife and child. He worked in the city, earned ₹40,000 per month, and believed that money could buy safety. He took Priya to a private hospital in the city.

Priya was seven months pregnant when they went for an ultrasound scan — ₹2,500. The radiologist looked at the screen for several minutes. "The baby is large," she said. "The head circumference is in the 90th percentile. The baby will be about 3.8 kilograms at birth." "Is that bad?" Priya asked, frightened. "Not bad. But for a first-time mother with a large baby, vaginal delivery can be difficult. Many women with babies this size need a Caesarean section."

What Priya didn't know: ultrasound estimates of fetal weight have a margin of error of ±15%. A baby estimated at 3.8 kg might actually be 3.1 kg — not "large" at all. And most women, regardless of baby weight, deliver vaginally. In developed countries like the USA, even babies weighing 4–4.5 kg are typically delivered vaginally unless there are other complications. The problem is not the baby's size. The problem is that the surgeon profits from Caesarean sections.

Priya came back at 38 weeks. The obstetrician — Dr. Chatterjee — examined her and ordered another ultrasound. "The baby is still large," she said. "I think we should schedule a Caesarean. We can do it at 39 weeks, before labor starts." Priya was alarmed. "But I thought we would try natural delivery first?" Dr. Chatterjee said: "Of course, if you want. But with a large baby, labor is risky. You could be in labor for 12–24 hours, exhausted, and then need an emergency Caesarean anyway. Isn't it safer to plan a Caesarean now?"

This is persuasion disguised as medicine. The surgeon is right that emergency Caesareans are riskier than planned ones. But she isn't mentioning that most women with large babies don't need emergency Caesarean, that vaginal delivery of a larger baby is faster and has fewer complications than Caesarean, or that she profits from the planned Caesarean. Vikram was convinced. "Let's do the Caesarean," he said. "No need to take risk." Priya wanted to argue, but she was scared. Everyone seemed to agree a Caesarean was safer. Maybe they knew something she didn't.

At 39 weeks, Priya was admitted. The Caesarean was straightforward. The baby — a girl — weighed 3.2 kg. Perfectly normal. The surgeon spent about 40 minutes in the operation theatre.

ITEM	COST
Pre-operative tests	₹2,000
Admission	₹1,500
Hospital bed (pre-op + 3 days)	₹8,000
Caesarean operation	₹20,000
Surgeon's fee	₹9,000
Anaesthesia	₹3,000
Medications	₹2,500
Nursing + monitoring	₹3,500
Total	**₹44,500**

Vikram paid. He felt he'd done the right thing — protected his wife and child. But Priya's body told a different story. A Caesarean is major abdominal surgery. Recovery takes 6–8 weeks. Pain at the incision site. Restricted movement. Cannot lift her baby for the first few days. A vaginal delivery would have meant recovery in 1–2 weeks. Full mobility immediately. Could hold her baby, move around, care for herself. By choosing "safety," Priya chose longer suffering.

— The Rate That Indicts the System

The WHO recommendation: Caesarean sections should account for 10–15% of all deliveries. Below 10%, maternal mortality increases. Above 15%, the harms outweigh the benefits. India's actual rates tell a different story entirely.

REGION / CATEGORY	C-SECTION RATE
WHO recommended maximum	15%
National average (India)	21.5%

REGION / CATEGORY	C-SECTION RATE
Government hospitals	14.3%
Private hospitals (national)	47.4%
Delhi (private)	55%
Mumbai (private)	52%
Bangalore (private)	48%
Richest 20% of women	52%
Poorest 20% of women	8%

The pattern is clear: wealth + private hospital = Caesarean. A woman earning ₹3 lakh per month at a private hospital has a 50%+ chance of Caesarean. A woman earning ₹20,000 per month at a government hospital has a 14% chance. Same country. Same women. Same pregnancies. Different outcomes based on ability to pay.

— The Mechanism

Private hospitals have financial incentives for Caesarean. Revenue per vaginal delivery: ₹8,000– 12,000 total hospital charge. Revenue per Caesarean: ₹35,000–50,000. Difference: 3–4x more revenue. Caesarean mothers stay 3–4 days; vaginal delivery mothers often go home after 1–2 days. Longer stay equals higher bed revenue. And there is no external audit of Caesarean indications, no physician review board examining necessity, no accountability if rates are abnormally high.

I joined this hospital five years ago. At that time, I was doing maybe 30% Caesareans. I maybe 20–25% of my Caesareans were not medically necessary. They were economically necessary — for me, for the hospital. My patients got major surgery they didn't need.

I joined this hospital five years ago. At that time, I was doing maybe 30% Caesareans. I thought that was high, but the senior doctors said it was "reasonable." Then my salary was restructured. Instead of a base salary, I now get ₹8,000 per Caesarean and ₹2,000 per vaginal delivery. Suddenly, the incentive was clear. A Caesarean is worth four vaginal deliveries. Within a year, my Caesarean rate went up to 45%. I didn't consciously decide to do more Caesareans. But when I had a woman in labor with mild complications, or slow progress, or any ambiguity — I started leaning toward Caesarean. The system made me choose Caesarean. Not maliciously. Just economically. Now, looking back, I believe maybe 20–25% of my Caesareans were not medically necessary. They were economically necessary — for me, for the hospital. My patients got major surgery they didn't need. But they thought they were getting safety. And I told myself the same thing.

CHAPTER 03

The Hysterectomy Belt

In Beed district, Maharashtra, something strange has been happening for the past decade. Women in their late thirties and early forties are having their uteruses removed. Not because of cancer. Not because of fibroids causing uncontrollable bleeding. Not because of life-threatening infection. But as a routine procedure — almost preventive.

A government survey in Beed district found: in one block with a population of 50,000 women aged 35–50, approximately 8,000 women had undergone hysterectomy in the past decade. That's 16% — in a 10-year period. In developed countries like the UK and USA, the hysterectomy rate is 3–5% even by age 70. Beed's rate at age 40 exceeds the USA's rate at age 70. This is not a health phenomenon. This is an economic one.

I met Kamala in a small village. She was forty-two, thin, quiet. "Why did the doctor say you needed a hysterectomy?" I asked. "He said my uterus was weak," she said. "He said if I didn't remove it now, I would have problems later." "What kind of problems?" "He didn't say exactly. But he said it was better to remove it now before something went wrong." "Did you have any symptoms? Heavy bleeding? Pain?" "No. I was fine. Still having periods normally. No pain. But the doctor said it was weak." "How long did it take to recover?" "Three weeks before I could do full work. But after the operation, something changed." "What changed?" "My body. I felt different. After three months, I stopped having periods — of course, I had the uterus removed. But I also started having hot flashes. Sweating at night. Mood changes. The doctor said these would pass. But it's been two years. They haven't passed." "Did anyone tell you about these side effects before the operation?" "No. The doctor said remove the uterus and you're done. I didn't know about hot flashes and all this."

—The Medical Reality

A hysterectomy is a permanent major surgery. Common side effects include early menopause (the uterus and ovaries are connected hormonally; removing the uterus can trigger menopause 3–5 years earlier than natural), hot flashes and night sweats (affecting 80% of women post- hysterectomy), mood changes and depression (40%), loss of libido (60%), vaginal dryness (70%), scar tissue complications that can cause pain, pelvic adhesions, and intestinal complications in later life, and increased risk of heart disease and osteoporosis due to early estrogen loss.

For a woman with genuine medical indication — cancer, uncontrolled heavy bleeding, infection — these side effects are acceptable. But for a woman with no symptoms, having major surgery to prevent hypothetical future problems is ethically questionable.

—The Data on Unnecessary Hysterectomy

The National Family Health Survey-5 (NFHS-5) findings were shocking. In Andhra Pradesh and Telangana, women aged 40–49: 20–23% have had hysterectomy. Women aged 50+: 30–35%. This is triple the rate in the UK, double the rate in the USA. The government commissioned audits and found that most hysterectomies did not meet clinical guidelines. Clinical guidelines for hysterectomy include uterine cancer, cervical cancer, endometrial cancer, uncontrolled heavy menstrual bleeding after conservative treatment has failed, uterine fibroids causing severe symptoms, pelvic inflammatory disease with complications, and uterine prolapse causing severe symptoms. A woman with a "weak uterus" is not on this list.

—The Economic Incentive

A hysterectomy in a private nursing home: hospital cost ₹3,000–5,000. Hospital charge: ₹12,000–20,000. Surgeon's fee: ₹5,000–8,000. Anaesthesia: ₹2,000–3,000. Total patient cost: ₹19,000–31,000. Hospital + surgeon profit: ₹10,000–20,000. Compare this to conservative treatment for heavy menstrual bleeding: iron supplements ₹500–800 per month, hormonal contraceptive pills ₹200–400, anti-inflammatory drugs ₹100–200. Over one year, conservative treatment costs ₹10,000–15,000 but requires ongoing consultation and monitoring. A hysterectomy is a one-time procedure with ₹20,000 profit per case.

When the National Health Authority introduced pre-authorization requirements for hysterectomies in 2022–23, hysterectomy rates dropped by 40–50% in areas with oversight. This tells us something important: when oversight is introduced, procedure rates drop. This means many of the previous procedures were not necessary.

CHAPTER 04

The Diabetes Business

In urban India, there's another pattern emerging. A 45-year-old man goes to a corporate hospital for a routine check-up. He's overweight, slightly hypertense, but has no symptoms. The hospital does a fasting blood sugar test. It's 105 mg/dL. Normal fasting glucose: less than 100. Pre-diabetes: 100–125. Diabetes: above 126. The result: 105. Technically pre-diabetes. The doctor says: "You have pre-diabetes. We need to start treatment immediately."

The patient says: "But I have no symptoms. I feel fine." The doctor says: "That's the problem with pre-diabetes. It damages your blood vessels silently. If we don't treat now, you'll have a heart attack in 5 years." The patient is frightened. He agrees to treatment.

The treatment plan: Metformin ₹500–800 per month (generic ₹200), repeat fasting glucose tests ₹400 every month, HbA1C test ₹1,000 every 3 months, lipid panel ₹800 every 3 months, liver and kidney function tests ₹1,500 every 6 months, annual ECG ₹1,000, annual eye check-up ₹1,500. Total annual cost: ₹8,000–10,000. Most of these tests are not necessary for a person with one elevated fasting glucose reading and no other risk factors.

What the hospital doesn't tell the patient: one elevated reading doesn't mean diabetes — a single fasting glucose of 105 can be due to stress, poor sleep, or diet the day before. Pre- diabetes often reverses: with modest diet and exercise changes, 50–60% of pre-diabetics revert to normal glucose levels without medication. Metformin for pre-diabetes is not evidence-based — major guidelines recommend lifestyle modification first. Monthly testing is not recommended — for someone with one reading of 105, re-testing in 3 months is appropriate.

The hospital profits because the patient becomes a "chronic disease patient" requiring ongoing care. Monthly visits mean monthly consultation fees. The tests generate lab revenue. The branded Metformin generates pharmacy revenue. The patient isn't being cured. The patient is being retained.

PART TWO

Commerce

Where the Money Goes

CHAPTER 05

The Doctor's Commission

Dr. Sharma is a GP in a middle-class neighborhood in Pune. He sees 40–50 patients a day. Most come with symptoms that could be viral infection, bacterial infection, or nothing serious. A 35-year-old woman comes in with fatigue and body ache. Dr. Sharma could examine her, diagnose viral illness, prescribe rest and symptomatic treatment. Cost to patient: ₹100 consultation + ₹200 medicine. Instead, he says: "Let's do some basic blood work. Just to rule out anything serious." The patient is slightly alarmed. "Do I need it?" "Better to be sure." The patient agrees.

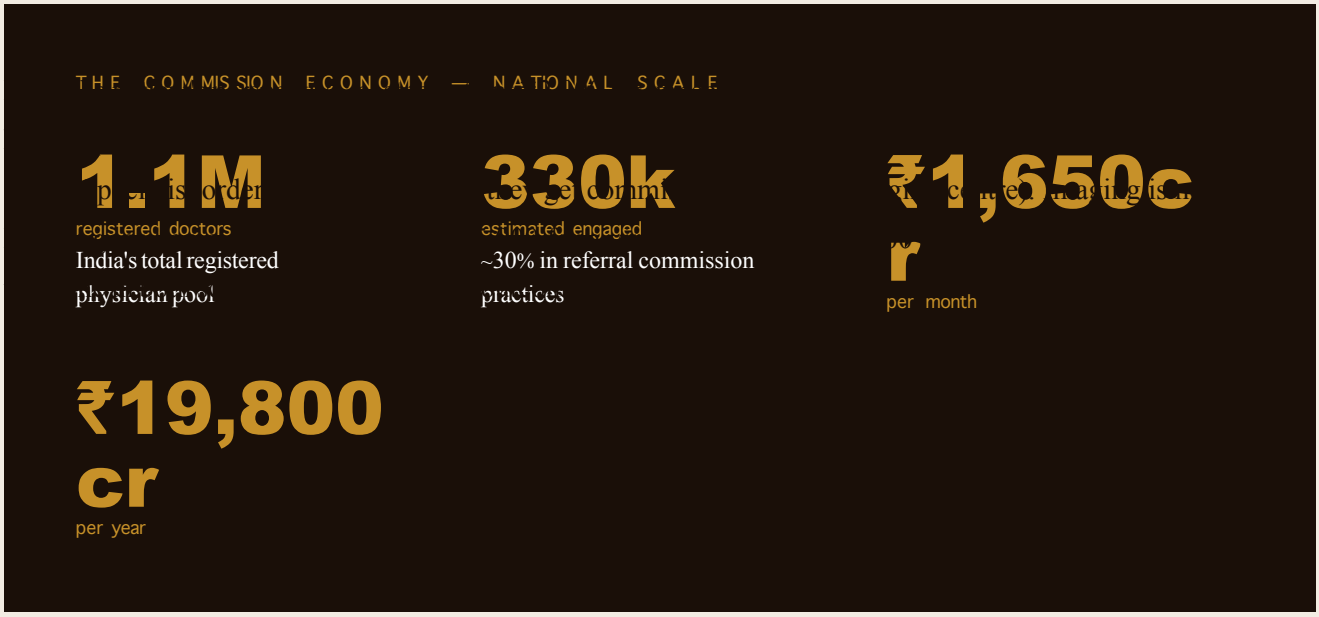
The Commission System Explained

Dr. Sharma ordered blood work from a pathology lab down the road — "Precision Diagnostics." The arrangement: Dr. Sharma refers patients to Precision Diagnostics; Precision Diagnostics gives Dr. Sharma a commission — typically 40–50% of the test cost. Dr. Sharma ordered tests costing ₹2,000. Dr. Sharma receives ₹800–1,000 in commission. The patient doesn't know this. The hospital doesn't disclose it. It's an informal arrangement. But it changes the incentive structure entirely. Dr. Sharma now sees every patient as a potential referral opportunity. Every symptom becomes a reason to test.

According to data from the Central Board of Direct Taxes (CBDT), this system is prevalent. In Circular 5/2012, the CBDT acknowledged that "freebies" from diagnostic companies to doctors exist and are taxable income. The government knows this happens. It's just not widely prosecuted.

The Referral Chain

The referral commission system extends beyond diagnostic labs. When Dr. Sharma refers a patient to a specialist, the specialist might give him 10–20% of the consultation fee. When the specialist orders imaging from a diagnostic centre, the centre gives 30–50% commission. By the time the patient is done, multiple people have



CHAPTER 06

Dolo-650 and the ₹1,000 Crore Question

On July 6, 2022, the Central Board of Direct Taxes conducted searches at 36 premises across 9 states. The target: a Bangalore-based pharmaceutical company. The allegations: giving ₹1,000 crore in "freebies" to doctors as bribes to prescribe their medicines. The case became public on July 14, 2022, when the CBDT issued a press release. By August 2022, the case reached the Supreme Court. Justice D.Y. Chandrachud commented: "This is not music to my ears... This is a serious issue."

The medicine in question: Dolo-650, a paracetamol tablet. Paracetamol is a basic fever medicine. Generic paracetamol 650mg tablets cost ₹2–3 per tablet. Yet, through inducements to doctors, the company was able to achieve massive sales at much higher prices. Yet the code governing this behaviour remains voluntary to this day.

—What Likely Happened

The company's strategy was probably: develop relationships with doctors through gifts, trips, and cash; incentivize doctors to prescribe the branded Dolo-650 instead of generic paracetamol; patients pay ₹15–20 per branded Dolo-650 tablet (5–10x the generic price); high volume sales, large margins, profits. The ₹1,000 crore the government alleged was the company's investment in "freebies" to generate these sales. If patients paid ₹15–20 per tablet and the company managed to sell 200 crore tablets per year (reasonable given population size), that's ₹3,000–4,000 crore in annual revenue. The ₹1,000 crore spent on inducements would yield ₹3,000–4,000 crore in return. ROI: 300–400%.

—The Response

The company denied the allegations. The executive vice president said: "The figures mentioned are arithmetically impossible." But here's what's important: even if the ₹1,000 crore figure is exaggerated, the practice of giving freebies to doctors is real. The CBDT acknowledged it in Circular 5/2012. Multiple investigations have found it. Doctors themselves acknowledge it in private. In November 2024, the Department of Pharmaceuticals issued guidelines making the UCPMP stricter. But the code is still not law. It's still voluntary. So companies can violate it with impunity.

CHAPTER 07

Paris, Monaco, and Accountability

In November 2024, the Department of Pharmaceuticals published an audit report on AbbVie Healthcare India. The findings: 24 doctors were sent to Paris for a 4-day "medical education conference." 6 doctors were sent to Monaco for a 4-day similar event. Total cost: ₹1,91,24,991 (approximately ₹1,600 per doctor per day, covering 4-star hotel, international flights, meals, and "conference fees"). Dates: various batches between 2022 and 2024. Who authorized it: AbbVie's top management.

—The Rules

India has a Uniform Code of Pharmaceutical Marketing Practices (UCPMP), first adopted in 2014 and updated in 2024. The rules state: companies cannot give gifts worth more than ₹1,000 per doctor per year; "sponsored educational activities" must be at recognized international conferences, not company-organized events; international trips are not permissible except for major scientific conferences; all gifts and educational support must be disclosed publicly.

AbbVie's Paris and Monaco trips violated these rules — cost per trip ₹15,000–18,000 (far above the ₹1,000 annual limit), not at a recognized international conference (they were AbbVie- organized events).

—The Consequences

For the 30 doctors: NMC received recommendations to initiate disciplinary proceedings. As of early 2025, no major consequences have been announced. For AbbVie: a report was filed. The company may face loss of UCPMP privileges and possible tax assessment. But no criminal prosecution, no major fine. For the system: nothing changed. Other pharmaceutical companies continue to do similar things. A doctor who receives a Paris trip worth ₹5,00,000 is naturally inclined to prescribe that company's drugs. Even if not always conscious bribery, the effect is the same: the doctor's prescribing is influenced by personal benefit, not by patient benefit.

The Case for Mandatory UCPMP

Currently, pharmaceutical companies are not required to follow UCPMP. It's voluntary. Dozens of doctors, patient advocacy groups, and medical ethicists have petitioned the government to make UCPMP mandatory and law. The petition argues: voluntary codes are routinely violated; enforcement is weak; patients are harmed when doctors' judgment is corrupted; a mandatory legal code would level the playing field. The Supreme Court has acknowledged the issue. A PIL is pending (as of 2024) asking the court to declare UCPMP mandatory. But progress has been slow.

CHAPTER 08

The Stent Story — How Price Controls Get Circumvented

In 2017, India did something dramatic and necessary. The National Pharmaceutical Pricing Authority (NPPA) capped the price of cardiac stents. Before the cap, a bare metal stent cost ₹25,000–₹3,00,000. A drug-eluting stent cost ₹1,50,000–₹4,00,000. There was no standard. Hospitals charged what they wanted. After the cap (February 13, 2017): bare metal stent ₹7,260; drug-eluting stent ₹29,600. This was an 85% price reduction overnight. Hospital and device companies said it was impossible. Patients would suffer. Quality would drop. None of that happened.

—What Actually Happened

Stent procedures continued. Hospitals continued doing them. Patients continued getting stents. The outcomes didn't change. But something else happened. The hospitals couldn't charge more for the stent itself. So they charged for other things.

ITEM	AMOUNT
Stent (capped)	₹29,600
Cardiac catheterization	₹35,000
Angiography	₹18,000
Interventional theatre charges	₹25,000
Cardiothoracic monitoring	₹8,000
ICU bed (1 night, precautionary)	₹5,000
Medications (post-procedure)	₹12,000

Diagnostic imaging	₹15,000
Consultation and interpretation	₹5,000

ITEM	AMOUNT
Hospital bed (2 days)	₹4,000
Total	**₹1,56,600**

The total was less than before (₹2,50,000), but not dramatically less. The regulatory agencies noticed this workaround. The NPPA issued additional guidelines restricting how much hospitals could charge for ancillary services. But enforcement is weak. The real solution is transparency: patients should know, beforehand, what they'll be charged for each component of care. A patient told what each item costs can shop around or refuse. But a patient given an itemized bill after discharge, with ₹1,56,600 in charges across 10 categories, has no choice but to pay.

> *Price controls work, but only if the system is monitored. Left alone, providers will find workarounds.*

CHAPTER 09

The Lab Empire and Unnecessary Tests

In India, there are more than 200,000 diagnostic labs. Only 1,000 are NABL-accredited (National Accreditation Board for Testing and Calibration Laboratories). That means 199,000 labs operate without external quality assurance.

An unaccredited lab might use outdated equipment, employ untrained technicians, lack quality control checks, and provide unreliable results. A patient who gets tested at an unaccredited lab might receive a false positive — told you have a disease you don't have, causing psychological trauma, unnecessary treatment, social stigma — or a false negative, missing a critical diagnosis and delaying treatment.

The Necessity Problem

But the bigger problem isn't accuracy. It's necessity. A patient with a cough comes to a doctor. Option A: examine the chest, listen to lungs, make a diagnosis, prescribe treatment. Cost: ₹100–200. Option B: examine the chest, then order chest X-ray (₹400), sputum test (₹600), blood culture (₹800), WBC count (₹200). Cost: ₹2,000. Most of the time, Option B tests are not needed. The examination was diagnostic. But if the doctor gets a commission from the lab (40–60% of test cost), the incentive is Option B.

Dr. Arun Gadre and Dr. Abhay Shukla, in their book *Dissenting Diagnosis*, interviewed 78 doctors about their prescribing practices. One doctor said: "I see so many tests being ordered for vague indications. A patient comes with fatigue. They get full thyroid panel, vitamin panel, full blood count, liver function, kidney function. Most of it's not indicated. But the lab pays commission, I get a cut, the patient pays ₹3,000–5,000."

Examples of Unnecessary Tests

Lipid panel for a 25-year-old with no family history of heart disease: Guidelines recommend starting lipid screening at age 35 for men and 40 for women, and only if there are risk factors. For a healthy 25-year-old, it's unnecessary.

Vitamin D test for anyone with fatigue: Fatigue has 100+ causes. Vitamin D deficiency is one. But testing everyone adds cost. Rational approach: treat with iron supplementation, thyroid screening, sleep assessment — then test Vitamin D if other causes are ruled out.

Thyroid function test for vague symptoms: Thyroid disease causes specific symptoms (weight change, temperature intolerance, hair changes). For vague fatigue, the test yields false positives because many people have slight TSH elevations without symptoms. This leads to unnecessary thyroid medication.

Full micronutrient panel for non-specific symptoms: Most people are not deficient in all of B12, folate, iron, copper, and zinc simultaneously. Testing 8–10 micronutrients generates false positives and leads to unnecessary supplementation.

Liver and kidney function tests for a patient with no liver or kidney symptoms: These are useful monitoring tools for people on medications that affect organs, or for people with known disease. For someone with an acute cough or cold, they're unnecessary.

If 40% of tests are unnecessary (a conservative estimate), that's ₹10,000 crore per year spent on testing that doesn't change patient outcomes. The Indian healthcare system does more lab tests per capita than many developed countries. Not because Indians are sicker, but because there's profit in testing.

CHAPTER 10

The Hospital Revenue Model

Corporate hospitals operate as profit centres. Every department is a cost centre that must generate revenue. The hospital administration sets targets. Surgery department: ₹50 lakh per month. Internal medicine: ₹40 lakh per month. Orthopedics: ₹35 lakh per month. Radiology: ₹30 lakh per month. Department heads are responsible for hitting targets. Their bonuses, their salary increments, their standing with administration — all depend on revenue.

—The Surgeon's Dilemma

A surgeon hits target by doing surgeries. If a patient has knee pain, the options are: physiotherapy and conservative management (₹5,000–10,000, low revenue), diagnostic imaging MRI and X-ray (₹8,000–15,000), or arthroscopic surgery (₹1,00,000–1,50,000, high revenue). If the surgeon is under pressure to hit a ₹50 lakh monthly target, conservative management doesn't help. Surgery does. Is the surgery always necessary? Sometimes yes, sometimes no. But the incentive structure makes it likely.

—The Internist's Dilemma

An internist manages common diseases — infections, hypertension, diabetes, asthma. To hit a ₹40 lakh monthly target with medical patients who have low average bill, the internist must admit more patients, keep patients admitted longer, order more tests and procedures, and refer to specialists for minor issues. A patient with simple pneumonia might need 3 days hospitalization (standard) but gets kept for 5 days (extended stay = higher revenue), gets imaging, blood cultures, and daily tests (increases bill), and gets referred to specialists for routine conditions. Total cost to patient: ₹40,000–60,000. If managed conservatively: ₹15,000– 20,000.

—The Obstetrics Department

We already discussed the C-section pattern. But it extends to other obstetric interventions. Induction of labor early increases length of stay and creates opportunity for C-section.

Episiotomy (surgical cut during labor) is overused as "preventive." Routine ICU admission postpartum extends stay and increases cost. The pattern is consistent: wherever there is a revenue target, clinical decision-making bends toward the more expensive option.

CHAPTER 11

A Doctor's Testimony

Dr. Sanjay is an internist at a 200-bed corporate hospital in Bangalore. I met him at a coffee shop, away from the hospital. He was anxious about being identified.

"

When I joined this hospital eight years ago, there was no revenue target. We had a salary. We saw patients. We tried to cure them. That was the job.

Three years ago, everything changed. The hospital was acquired by a larger corporate chain. Suddenly, there was a new model. Every department got a monthly revenue target. For internal medicine, it was ₹40 lakh per month.

₹40 lakh. Let me do the math. If I have 20 patients on the ward at any time, and average stay is 3 days, that's about 200 patient-days per month. To hit ₹40 lakh target on 200 patient-days, I need to generate ₹2,000 per patient-day. The cost of a hospital bed is maybe ₹500–700 per day. So to hit target, I need ₹1,300 more per patient-day. Where does that come from? Tests. Procedures. Consultations. Specialty referrals.

A patient with pneumonia needs antibiotics. That's ₹200–300. But if I order a CT chest (₹4,000), a blood culture (₹800), a bronchoscopy (₹8,000), specialty pulmonology consult (₹1,500), then the bill is much higher. Is all that necessary? Sometimes. But increasingly, it's not. It's revenue-driven.

Within a year, my average patient bill went up from ₹20,000 to ₹35,000. I hit my target. But I started feeling like I was cheating my patients.

Then one day, a 65-year-old man came in with mild gastritis. Acid reflux. Simple indigestion. Nothing serious. I could have discharged him with antacids. Cost: ₹200. Instead, I admitted him. Ordered ultrasound (₹2,000), CT scan (₹4,000), endoscopy (₹3,000), referred him to a gastroenterologist (₹500 consultation). Plus hospital bed for 3 days (₹6,000) plus medications (₹1,500). Total: ₹17,000. The endoscopy showed mild gastritis. The CT was normal. The ultrasound was normal. The only abnormal finding was in my own conscience.

A few weeks later, I got feedback from the hospital. I was told I was ₹5 lakh short of target for the month. The feedback said: "Need to improve efficiency." Efficiency. That word doesn't mean treating patients efficiently. It means extracting money efficiently.

I realized I couldn't do this anymore. But here's the thing: I'm trapped. If I don't hit targets, my salary suffers. I have a mortgage. I have kids in school. If I leave this hospital and go to another, I'll face the same thing. All corporate hospitals work like this. The only way out is a government hospital, but those have their own problems. So I stay. I hit my targets. I order tests I'm not sure are necessary. And I feel complicit in a system that exploits patients.

— DR. SANJAY, INTERNIST, 200-BED CORPORATE HOSPITAL, BANGALORE. NAMECHANGED.

PART THREE

Testimony

Voices from Inside the System

III

CHAPTER 12

The Nursing Perspective

Nurses are at the frontline of healthcare. They spend more time with patients than doctors do. They see the system's contradictions. Three nurses spoke — one from a corporate hospital, one from a government hospital, one from a small private nursing home. All asked for anonymity.

—Meera — Corporate Hospital Nurse

I've worked here for four years. The pay is decent, but there's no job security. I'm on contract, renewed annually. What that means: if I cause problems, I'm out. And there's a line of 50 people ready to take my job.

I've assisted in procedures that I know weren't necessary. A woman having a hysterectomy for fibroids that caused no symptoms. A man having a second stent even though he already had three. A child getting admitted to ICU for observation when a regular bed would have been enough. When I've tried to speak up, to ask a doctor: "Is this really needed?" I get shut down. One time, I said: "This ICU admission seems precautionary, not medically necessary." The doctor said: "If you're not comfortable, I can find another nurse." That ended the conversation.

I have a mortgage. I can't afford to lose my job. So I do what I'm told. I assist in procedures. I monitor patients. I provide care. But I've compromised on something I started medicine to do: advocate for patients when their interests conflict with hospital interests. The system has made me complicit.

— MEERA, CORPORATE HOSPITAL NURSE. NAME CHANGED.

—Rajesh — Government Hospital Nurse

I work in a 600-bed government hospital. The conditions are tough. We're understaffed.

Salaries are low. Infrastructure is poor. But here's the advantage: I have job security. I'm a permanent government employee. No one can fire me for speaking up. So when I see something wrong, I can advocate for the patient.

Just last month, a woman came in for a normal delivery. The labor ward was full, so she was placed in the general ward. The obstetric resident wanted to admit her to ICU "for monitoring" because the ICU had empty beds. I objected. I said: "She has no complications. Labor is progressing normally. ICU is for critical patients." The resident backed down. The woman stayed in the general ward, delivered normally, and went home.

I could do that because I'm secure. If I were on contract, I'd keep quiet. That's the real problem. The system that pays nurses insecurely creates ethical compromises. For a system to function with integrity, it needs people who can afford to be ethical. And that means job security.

— RAJESH, GOVERNMENT HOSPITAL NURSE. NAME CHANGED.

—Priya — Small Nursing Home Nurse

I work at a 15-bed nursing home. The owner is a surgeon, and he uses this place as a profit center. When a patient is admitted, I'm told to ensure they stay as long as possible. If they seem ready to discharge on Day 2, I suggest: "One more day for rest. Let the wound settle. Safe recovery is more important than hurrying." Most patients agree.

I'm also responsible for noting down everything the doctor does — to justify the charges. Sometimes the documentation inflates what actually happened. A patient might get basic wound dressing. But I'm told to document it as "advanced wound care with dressing materials and specialist nursing." This inflates the bill. I feel bad doing it. But it's part of the job. The surgeon doesn't explicitly tell me to lie. But the incentive structure makes lying part of the job description. I've compromised on my integrity.

— PRIYA, NURSING HOME NURSE. NAME CHANGED.

CHAPTER 13

The Whistleblower Trap

In a system built on profit, whistleblowers are dangerous. Dr. Vikram — an orthopedic surgeon with 10 years of experience at a large corporate hospital in Mumbai — was willing to share his story.

"

In my second year there, I noticed a pattern. Patients with simple knee pain were being sent to imaging (MRI, often unnecessary). Based on minor findings on imaging, they were being scheduled for arthroscopic surgery. I started to object. I would tell patients: "Let's try physiotherapy first. Imaging and surgery are not indicated yet." The hospital administration called me in. They said: "Your surgery numbers are low. Your efficiency is poor." I said: "My surgery numbers are low because I don't do unnecessary surgery." They said: "We have benchmarks. You're not meeting them." I asked: "Who set these benchmarks? Are they evidence-based?" They said: "The industry standard is 5 surgeries per surgeon per week. You're doing 2.5."

A few months later, my salary review came. My raise was withheld. I requested a meeting with the hospital director. He was kind, but firm. He said: "The hospital has investors. We have to meet revenue targets. If you can't contribute to those targets, maybe this isn't the right place for you."

I could have escalated. I could have gone to the Medical Council. I could have gone to the media. But I had a mortgage, kids in school, loans from my medical education. A scandal would destroy my career. Whistleblowing would mean conflict with my employer, possible firing, damage to my reputation, difficulty getting a job elsewhere (hospitals would see me as a "troublemaker"), and lengthy legal battles. Against all that: the moral satisfaction of fighting a wrong system. The calculation was simple. I couldn't afford to whistleblow.

So I left the hospital quietly and found a smaller practice where revenue targets are less stringent. But I didn't speak up. The system continues. That's how the system maintains itself: by making whistleblowing too costly for most people. The people who can afford to speak up are rich, already established, near retirement, or already marginalized. Most doctors are none of these.

— DR. VIKRAM, ORTHOPEDIC SURGEON, MUMBAI. NAME CHANGED.

PART FOUR

Rural India

Healthcare in the Forgotten Parts

CHAPTER 14

The Quack Economy

In a village of 5,000 people, the nearest government hospital is 25 kilometers away. The nearest private hospital is 50 kilometers away. But the village has a "doctor" — a man who got some medical training 20 years ago, or read some medical books, or just decided one day that he was knowledgeable enough. He's called an ASHA, or a compounder, or just "doctor." He has a small clinic, sometimes just a room in his house. He sells medicines: antibiotics, steroids, painkillers, antihistamines. He gives injections: almost always, three injections for any condition — antibiotic, steroid, and something for pain. He charges ₹50–200 per visit. For most villagers, this is accessible. A government hospital would require a bus journey costing ₹200–300, and waiting time costing hours. The quack is right there.

The quack rarely has formal medical training. He doesn't know how to diagnose properly, which antibiotics to use for which infections, contraindications or drug interactions, or when to refer to a hospital. He treats by trial and error, or by pattern matching. The outcomes are variable: sometimes the patient gets better (and thinks the quack cured them); sometimes the patient gets worse, and then goes to the city hospital where treatment costs ₹50,000; sometimes the patient develops complications from inappropriate treatment.

—Antibiotic Resistance

The bigger problem: inappropriate antibiotic use creates resistance. The quack prescribes antibiotics for viral infections (which don't need them). The antibiotics don't work (because the infection is viral), so he prescribes a stronger antibiotic. Eventually, bacteria in that person's body become resistant to multiple antibiotics. When that person develops a serious infection later — say, a urinary tract infection — the bacteria are resistant to common antibiotics.

Treatment becomes difficult and expensive. Multiply this by thousands of villagers using quacks, and you have a public health crisis: antibiotic-resistant bacteria spreading through the population.

—Why Regulation Is Weak

The Clinical Establishments Act says all medical practitioners must be registered. In reality, quacks operate openly, without registration. Why aren't they shut down? First, the government

doesn't have enough staff to monitor every small clinic. Second, the quack is often connected to local political figures who protect him. Third, in areas with no real doctor, the quack is the only option. Closing him down would leave villagers with no access at all.

A villager sick with pneumonia faces this choice: go to the quack, pay ₹100, take injections that might or might not work, possibly get worse — or travel 25 km to government hospital, pay ₹300 in transport, wait 4 hours, get proper diagnosis, stay overnight, spend ₹2,000, but get evidence-based treatment. Most choose the quack first. If it works, they think the quack was good. If it doesn't work, they wait until it becomes serious, then do the hospital option at greater cost.

CHAPTER 15

Ayushman Bharat — Promise and Reality

In 2018, the Indian government launched Ayushman Bharat, also known as PMJAY (Pradhan Mantri Jan Arogya Yojana). The scheme: every poor family (about 10 crore people) gets ₹5 lakh of free hospital care per year. The promise: end catastrophic health expenditure. No more families going bankrupt from illness.

16.5cr	31,987	3cr+	₹1L cr
BENEFICIARIESENROLLED	EMPANELLEDHOSPITALS	ADMISSIONSCOVERED	TOTAL GOVERNMENTCOST

—The Fraud Problem

In August 2025, the National Health Authority reported: fraudulent claims rejected — 3.56 lakh cases worth ₹643 crore. Hospitals de-empanelled: 1,114. Hospitals penalised: 1,504 with ₹122 crore in fines. Hospitals suspended: 549. Examples of fraud included fake patients (hospitals created fictitious patients and billed the scheme), inflated procedures (a simple treatment billed as a complex procedure), unnecessary hospitalization (a patient who could have been treated as an outpatient was admitted), and double billing (patients were billed both by the hospital and the scheme).

—The Unintended Consequence

The scheme was meant to help the poor. But it created a new target for exploitation. Some hospitals realized: "We can bill the scheme aggressively, and the patient won't object because they're not paying." A beneficiary admitted for a simple infection might get an extended hospital stay of 5 days instead of 2, unnecessary imaging worth ₹5,000, specialist consultations that add nothing (₹3,000 each), and expensive medicines (₹10,000 for something that cost ₹1,000 generically). The hospital bills the scheme ₹40,000. The scheme pays. The patient thinks

it's free. But the patient is still being exploited — the money is just coming from government rather than from their pocket. And government money comes from taxpayers.

The Accessibility Problem

To use PMJAY, a patient must have the PMJAY card or be able to register for one, go to an empanelled hospital, get pre-authorization from the scheme, and wait for approval (often 2–3 days). For an urban patient with internet access and nearby empanelled hospitals, this is doable. For a rural patient 30 km from the nearest empanelled hospital, with no internet and no understanding of the process, it's a barrier. Many rural patients never use PMJAY, even though they're eligible, because the process is too complicated.

PMJAY has partially succeeded. Millions of families have avoided bankruptcy because of it. But it hasn't solved the underlying problem: the healthcare system is too expensive. It has just shifted the bill from the family to the government. The overcharging continues. The unnecessary procedures continue. The profit motive is undiminished. What PMJAY needed to come with: price controls (all procedures should have capped prices, standardized across India), outcome monitoring (hospitals should be audited for whether they're doing procedures appropriately), and patient rights (patients should be able to refuse unnecessary procedures and demand itemized bills). None of this happened.

CHAPTER 16

A Mother's Death

In a village in Bihar, a 32-year-old woman — Kavita — was pregnant with her third child. Her first two had been born at home, with a traditional midwife (dhai). Both deliveries were normal. She had no complications. With her third pregnancy, the government health worker said: "You should deliver at a health facility. It's safer." Kavita agreed. She went to the Primary Health Centre (PHC) in her block, 12 km away.

The PHC had one ANM (Auxiliary Nurse Midwife) and no doctor. When Kavita went into labor, she was admitted. The ANM examined her. Labor seemed normal. After 8 hours of labor, the ANM realized something was wrong. The baby wasn't descending. Possible obstruction. The ANM called the district hospital, 35 km away. "Send an ambulance," she said. The ambulance took 90 minutes to arrive.

By then, Kavita was in severe pain. Her blood pressure was dropping. The baby's heart rate was irregular. At the district hospital, the doctor realized: placental abruption. The baby was being deprived of oxygen. An emergency Caesarean section was done. The baby was stillborn. Kavita survived, but barely. She needed a blood transfusion and ICU care. Total cost: ₹80,000. Kavita's family paid ₹40,000 from savings. The rest came from PMJAY.

The Analysis

What went wrong? If Kavita had had proper antenatal monitoring, the risk of placental abruption might have been detected. The PHC had no ultrasound, no CTG (fetal monitoring), no capability to handle emergencies. A 90-minute ambulance delay in an obstetric emergency is nearly fatal. Kavita was directed to a PHC that couldn't handle her case instead of being advised to deliver at the district hospital from the start. The system failed at multiple levels.

Every day, in rural India, maternal complications are mismanaged due to inadequate infrastructure and delays in care. Some mothers die. Some babies die. Some survive but with disabilities. If a woman dies from a preventable cause (obstetric hemorrhage, infection, eclampsia), it doesn't show up in hospital mortality statistics because she died at a PHC or on

the way. If a baby is stillborn due to lack of fetal monitoring, it's not counted as a hospital outcome. These deaths are invisible in the system.

PART FIVE

The Roots

Why the System Works This Way

V

CHAPTER 17

Medical College and the Seeds

Every doctor in India enters through one of two paths. The first: merit. Top 1% of NEET scorers get seats in government medical colleges. Cost: ₹10,000–50,000 for the entire 5- year course. Quality: usually high. This path is extremely competitive. 18 lakh students take NEET. 1 lakh get seats. Less than 0.6% succeed. The second: money. Those who don't make the top 1% but have money go to private medical colleges. Official cost: ₹20–40 lakh for the 5- year course. Unofficial cost (capitation fee): ₹50 lakh to ₹2 crore. This is an open secret.
Everyone knows about it. It happens openly. The capitation fee is paid as cash or wire transfer to a private account — not on official receipts.

A student pays ₹1 crore to get into medical college. Now, the question: after spending ₹1 crore on your education, how do you recoup that money? The answer: by charging high fees, taking commissions, ordering unnecessary tests, and treating patients as revenue sources. You have to. You're in debt.

— The Inequality This Creates

The medical profession ends up stratified by wealth. Top tier (merit-based): government college, no debt, low pressure to profiteer, can afford to be ethical. Bottom tier (money-based): private college, ₹1 crore debt, high pressure to profiteer, incentive to exploit patients. The entire profession is shaped by whether you earned your way in or paid your way in.

The NMC has guidelines about capitation fees, but enforcement is nearly non-existent. Colleges openly charge capitation fees. Students openly pay them. The NMC does nothing. Why? Many NMC members come from private colleges and benefit from capitation fees. Enforcement requires investigation and prosecution, which requires political will. There's no whistleblower protection for students or staff who report capitation fees. So the system continues.

An honest government college doctor gets demoralized when they see private college doctors earning 10x more through questionable means. The incentive structure shifts: being ethical is being economically irrational. Over time, the profession loses its moral compass.

CHAPTER 18

Why Regulators Sleep

India has institutions designed to protect patients. The NMC (National Medical Commission) regulates doctors, approves colleges, investigates complaints. The NPPA (National Pharmaceutical Pricing Authority) sets drug price caps. The CDSCO (Central Drugs Standard Control Organization) approves drugs and inspects factories. The UCPMP (Uniform Code for Pharmaceutical Marketing Practices) is a code of conduct for pharma companies — voluntary. The Clinical Establishments Act mandates standards for hospitals and clinics. On paper, these are strong institutions. In practice, they're weak.

— The NMC's Failure

The NMC received over 1,800 complaints against doctors in 2024 (according to Parliamentary records). How many resulted in action? 112. That's 6%. Where did the remaining 94% go?
Incomplete investigation. Lost in bureaucracy. Quietly closed. Why? The NMC has perhaps 100 staff to investigate 1,800+ complaints per year — that's 18 complaints per staff per year, impossible to do thoroughly. Medical cases are technically complex, requiring expertise that good investigators rarely have. Powerful doctors have connections, and complaints against them "mysteriously" get delayed. And without whistleblower protection, patients who report doctors often face retaliation, so few people file complaints.

—The NPPA's Limitation

The NPPA has capped prices for about 500 essential medicines. There are tens of thousands of medicines in use in India. The capped medicines are important (antibiotics, heart drugs, etc.), but the gaps are huge. Many expensive medicines fall outside caps. Hospitals can charge whatever they want. And even for capped medicines, hospitals find workarounds — bundling into procedures, inflating ancillary charges.

—The CDSCO's Laxness

The CDSCO approves drugs for use in India. Standards are lower than in developed countries. Drugs that are banned in the USA or Europe are still approved in India. Some drugs that appear

in the CDSCO database have never been proven safe by clinical trials in India — they're approved based on "traditional use" or "expert opinion." The CDSCO issues regular alerts about counterfeit and substandard drugs but has limited enforcement capacity.

— The Clinical Establishments Act's Non-

The Act mandates standards for hospitals: hygiene, equipment, qualifications of staff, etc. But most states don't enforce it. A hospital can operate sub-standard and face no consequences. The Act has been called "a law that exists on paper but not in practice."

CHAPTER 19

The Media and Healthcare Reporting

The Indian media, with rare exceptions, doesn't do investigative healthcare reporting. Why? First, advertising revenue: hospitals advertise heavily in media. Exposing hospital scams alienates advertisers. Second, complexity: healthcare is technically complex, and reporters often don't understand it well enough to investigate. Third, pressure: hospitals are often influential. They can threaten lawsuits, withdraw advertising, use connections to marginalize journalists. Fourth, economic incentive: quick news sells; investigative healthcare reporting takes months and is harder to sell.

So corruption in healthcare remains invisible. Patients don't know. The public doesn't know. The system maintains itself through silence.

> *The system is designed to be silent. The media that could break that silence has been bought by the same system it should be exposing.*

PART SIX

Resistance

V

What Patients Can Do

CHAPTER 20

Questions Every Patient Should Ask

By now, you understand the system. You know it's designed to extract money from the sick. But you still need treatment. So here is a practical guide: questions you should ask, and why.

— Before Any Procedure

QUESTIONS TO ASK BEFORE ANY TEST OR PROCEDURE

1. **Is this test/procedure necessary?**
   Ask: "How will this change my treatment? What will you do differently based on the results?" If the doctor can't give a clear answer, the test probably isn't necessary. Many tests are ordered out of habit or for revenue, not for medical indication.
2. **What are the alternatives?**
   Every disease has multiple treatment paths. Surgery vs. medication. Branded vs. generic. Hospital vs. home care. The doctor should explain why they're choosing the specific path.
3. **What's the success rate for this specific hospital?**
   "Of the last 100 patients who had this procedure here, how many had good outcomes? How many had complications?" A doctor's outcomes vary. You deserve to know.
4. **Is this emergency or elective?**
   Do I need this done today/this week? Or can I wait to get a second opinion? True emergencies need immediate treatment. Most other things can wait 2–3 days.
5. **Can I get a second opinion?**
   A good doctor will encourage second opinions. A doctor who discourages it is a red flag. Surgery is permanent. You deserve multiple perspectives before committing.

— During Hospitalization

QUESTIONS TO ASK WHILE ADMITTED

1. **Can I see an itemized bill before discharge?**
   Don't accept a rounded-off total. Ask for every item broken down: bed charges per day, medications listed individually, each test named with cost, specific procedure names, doctor visits, nursing care. If a hospital refuses, that's a sign they're hiding markups.
   You have the legal right to know what you're paying for.
2. **Will you read the consent form to me?**
   Don't sign blindly. If it says "I consent to necessary procedures," cross it out and write: "I consent only to [specific procedure name]." The Samira Kohli case established that blanket consent is invalid.
3. **Am I PMJAY-eligible? Is this hospital empanelled?**
   If you're a PMJAY beneficiary and the hospital is empanelled, you shouldn't pay anything. Confirm this before admission. Some hospitals charge poor patients directly instead of processing through PMJAY.
4. **Do you get commission from this lab/hospital/specialist?**
   Directly ask: "Do you have financial interest in referring me here?" The doctor might lie. But the question puts them on notice.

— For Specific Conditions

FOR PREGNANCY — C-SECTION

1. **Ask for the specific clinical indication.**
   Legitimate reasons: previous Caesarean, breach presentation, fetal distress. Weak reasons: large baby (most large babies deliver vaginally), doctor's convenience (definitely not valid).
2. **If your doctor's Caesarean rate is above 40%, consider changing doctors.**
   WHO recommends 10–15%. A rate of 40–55% means money is influencing clinical decisions.

FOR CHEST PAIN

1. **Before getting a stent, you should have:**

an actual confirmed cardiac artery blockage on angiography, clear symptoms, failed medical management, and confirmation by a second cardiologist. Not just: "It might happen, so let's put in a stent."

FOR BACK PAIN

1. **Surgery should be the last resort, not the first option.**
   Most back pain resolves with physiotherapy, exercise, and time. Ask for: duration of symptoms (surgery is for chronic pain, not acute), conservative treatment attempted (physiotherapy first), and MRI findings — but remember that imaging findings don't always match clinical symptoms.

— For Medicines

MEDICINES — ALWAYS ASK THESE

1. **Can I take the generic version instead of brand?**
   Generic medicines are chemically identical to branded ones. Cost is 50–70% less. Always ask for generic. You have the legal right to request generic medicines.
2. **Is this medicine necessary immediately, or can I try diet/exercise first?**
   For hypertension, diabetes, cholesterol — often lifestyle modification is tried first. Some doctors skip directly to medicines for revenue reasons.
3. **What are the side effects?**
   Ask for the list of common side effects and rare serious side effects. Ask what to do if side effects occur.

— After Treatment

AFTER DISCHARGE — ALWAYS DO THESE

1. **Get copies of all reports and imaging.**

You have the legal right to your medical records. Get: discharge summary, pathology reports, imaging (X-rays, CT, MRI), specialist reports, operative notes if surgery was done. Store them safely.

2. **Ask which follow-up is essential and which is optional.**
   Some doctors push excessive follow-up visits. Not all follow-up is equally necessary.

3. **Get complaint contacts before you leave.**
   Hospital's grievance committee, NMC for doctor complaints (nmc.org.in), consumer court (district or state), PMJAY grievance (pmjay.gov.in). Save these before discharge.

CHAPTER 21

The Consumer Court Path

If a hospital overcharges, performs an unnecessary procedure, or provides negligent care, you have legal recourse. The Consumer Protection Act, 2019, treats medical service as a "service," and healthcare negligence falls under this.

— How to File a Complaint

Step 1: Gather Documents. Collect the hospital bill (itemized), medical records, any communication with the hospital, proof of payment, second opinion if you got one, and any evidence of wrongdoing.

Step 2: Send Demand Notice. Write a formal letter to the hospital detailing what was done, why you believe it was wrong or overcharged, medical evidence if you have expert opinion, the amount of compensation sought, and a deadline for response (usually 30 days). Send by registered mail. Keep proof of delivery.

Step 3: File Consumer Complaint. If the hospital doesn't respond or refuses, file at: District Consumer Dispute Redressal Commission for claims up to ₹50 lakh; State Commission for ₹50 lakh to ₹2 crore; National Commission for above ₹2 crore. File online at consumer.gov.in or in person.

Step 4: Hearing. The commission will ask the hospital for a response. The hospital will present their side. You'll present your evidence. The commission will issue judgment.

Step 5: Enforcement. If judgment is in your favor, the hospital must pay. If they refuse, you can apply for enforcement through courts.

— Typical Outcomes

In cases where hospitals clearly overcharged or performed unnecessary procedures: partial refund (the commission often reduces the bill by 30–50%); compensation — additional compensation for mental suffering, loss of time (typically ₹50,000–5,00,000); exemplary

damages if misconduct is egregious, to deter future behavior. Timeline: 1–3 years from filing to final judgment.

CHAPTER 22

The Regulatory Route

Instead of a personal complaint, you can report to regulatory bodies.

National Medical Commission (NMC)

The NMC investigates complaints against doctors. File online at nmc.org.in or in writing to: National Medical Commission, 3rd Floor, Medical Council of India Building, New Delhi.
Include the doctor's name, qualification, and registration number; what happened (date, place, details); how you were harmed; evidence (medical records, photos, witness contact); and what you're seeking. The NMC will send a copy to the doctor for response. Investigation may take 6 months to 2 years. Disciplinary action if found guilty: reprimand, suspension, or cancellation of license. Note: NMC is slow (6–24 month average wait), enforcement is weak, and only about 6% of complaints result in action.

Ministry of Health / NHA (for PMJAY Beneficiaries)

If you're a PMJAY beneficiary and faced fraud or overcharging, report to the PMJAY Helpline: 14555 or 1800-180-8080, or online at pmjay.gov.in. The NHA will audit the hospital. If fraud is confirmed, the hospital is penalised or de-empanelled, and you get a refund if overcharged.

State Health Authority

For complaints about government hospitals or general health issues, contact your state's Health Secretary or Chief Medical Officer. Include similar documentation as an NMC complaint.

CHAPTER 23

What You Can Do Today

Personal Level

ACTIONS YOU CAN TAKE STARTING NOW

1. **Learn your rights.**
   Read the Samira Kohli judgment (available online). Understand that consent must be specific, informed, and written.
2. **Next time you see a doctor:**
   Ask "Is this test necessary?" Ask "What's the cost?" Ask for a second opinion before any surgery.
3. **Get copies of all medical records.**
   Even if everything is fine, get copies. Store them. You might need them later.
4. **For chronic conditions:**
   Take generic medicines instead of branded. Cost savings could be 50–70%.
5. **Share knowledge.**
   If a friend or family member is facing overcharging, overtreatment, or malpractice, share this book with them.

Family Level

FAMILY PREPAREDNESS

1. **Have a conversation about healthcare decisions.**
   Discuss in advance: what kind of treatment you'd want if seriously ill, who should make decisions if you can't, preference for government vs. private care.
2. **Create a health record folder.**
   Keep all family members' medical records in one place. Update annually.
3. **Choose a primary care doctor**
   Instead of going to random doctors, establish a relationship with one good doctor who knows your health history.

Community Level

COMMUNITY ACTIONS

1. **Form a patient advocacy group in your neighbourhood.**
   Meet monthly. Share experiences. Collectively approach hospitals for accountability.
2. **Use RTI (Right to Information Act).**
   File RTI applications asking for: government hospital's C-section rates, government hospital's mortality statistics, complaint statistics and action taken. Make this data public. Transparency creates accountability.
3. **Report fraud.**
   If you witness overcharging or fraud at government hospitals or PMJAY hospitals, report to the hospital's grievance committee, NHA for PMJAY (14555), or local media.

Advocacy Level

POLICY-LEVEL ADVOCACY

1. **Support policy change.**
   A PIL is pending in Supreme Court asking for UCPMP to be made mandatory. Support organizations pushing for this: Jan Swasthya Abhiyan (jsaindia.org), SATHI Pune (info@sathicehat.org), Alliance of Doctors for Ethical Healthcare.
2. **Write to your representatives.**
   Email your MP, MLA, and Chief Minister asking them to: make UCPMP law (not voluntary), enforce itemized bills in all hospitals, strengthen NMC enforcement, regulate capitation fees in medical colleges.
3. **Use social media and media**

   If you experienced healthcare injustice, consider going public (with privacy protection if needed). Stories are powerful. Media picks up real stories of patients harmed by overtreatment or malpractice.

The System Can Change

This book has been bleak. It's shown you exploitation, profit-driven care, and weak regulation.
You might ask: Is change possible? Yes. But not automatically.
Change comes from pressure — patient pressure, media pressure, political pressure.

In 2017, stent prices were capped at ₹7,260–₹29,600. Before that, patients paid ₹2,00,000–₹4,00,000. This wasn't from regulation alone. It was from patient advocacy groups publicizing the exploitation, media coverage showing patients going bankrupt for stents, political parties making it an election issue, and civil society pressure. The government acted.

What could change: if UCPMP is made mandatory, doctor-company corruption drops dramatically. If itemized bills are mandatory, overcharging becomes visible and hospitals would have to justify every charge. If C-section rates are published per hospital, high-rate hospitals would face pressure to reduce unnecessary surgeries. If capitation fees are banned, new doctors would have less debt and less incentive to exploit patients. If NMC gets more resources and staff, it could actually investigate the thousands of complaints it receives. None of this requires new laws. Most of it just requires enforcing existing rules.

When you ask a doctor "Is this test necessary?" you're creating accountability. When you demand an itemized bill, you're making overcharging visible. When you report fraud to PMJAY or the health ministry, you're triggering investigation. When you share this book with a friend who faced exploitation, you're spreading awareness. When you vote for politicians who promise
healthcare reform, you're creating political pressure. Individual actions seem small. But collectively, they drive change.
This book is written for the person with education and access to read it. But the people most harmed by this system — poor, rural, illiterate Indians — don't have access to this book. If you've read it, you have knowledge.

]

Do something with it. The system is designed to be silent.

APPENDICES

Reference

Contacts · Laws · Templates · Resources

A

APPENDIX A

Essential Contacts and Helplines

SERVICE	NUMBER / CONTACT	PURPOSE
PMJAY (Ayushman Bharat)	14555	Scheme queries, hospital complaints
National Consumer Helpline	1915	Consumer complaint guidance
IRDAI Insurance Ombudsman	155255	Insurance grievances
Jan Aushadhi (Generic medicines)	1800-180-8080	Affordable medicine info
Poison Control	1800-118-0011	Drug adverse effects

Regulatory Bodies

ORGANIZATION	WEBSITE		FUNCTION
NMC (Doctor complaints)	nmc.org.in	Docto r	discipline, college approval
NPPA (Drug prices)	nppaindia.nic.in		Price cap information
CDSCO (Drug safety)	cdsco.gov.in		Drug approval, adverse effects

ORGANIZATION	WEBSITE	FUNCTION
Consumer Portal	consumer.gov.in	File consumer complaints online

Patient Advocacy Organizations

ORGANIZATION	PURPOSE	CONTACT
SATHI Pune	Health activism, rural health	info@sathicehat.org
Jan Swasthya Abhiyan	Health advocacy, policy change	jsaindia.org
Alliance of Doctors for Ethical Healthcare (AdEH)	Doctors against corporate medicine	via social media
	Medico Friend Circle	

Health monitoring,	research	Delhi-based
Consumer Education and Research Centre	Consumer advocacy	cerc.org.in

APPENDIX B

How to File a Consumer Complaint

— Online Filing

Step 1: Visit consumer.gov.in and click "File Complaint."

Step 2: Fill details: your name, address, contact; hospital/doctor name and address; amount claimed; what happened (detailed description); relief sought (refund, compensation, action against doctor).

Step 3: Attach documents: hospital bill (itemized), receipts of payment, medical records, opinion letter from a second doctor if available, any correspondence with hospital.

Step 4: Submit and get registration number. Track status online.

Offline Filing

Visit the District Consumer Dispute Redressal Commission in your city. Get the form, fill it, and submit in person.

Jurisdictions

FORUM	CLAIM AMOUNT
District Consumer Dispute Redressal Commission	Up to ₹50 lakh
State Commission	₹50 lakh to ₹2 crore
National Commission	Above ₹2 crore

Timeline: Average 18 months to 3 years. Some simple cases: 6 months to 1 year. Complex cases: 3–5 years.

APPENDIX C

Key Judgments and Laws

Supreme Court Judgments

Samira Kohli v. Dr. Prabha Manchanda (2008) 2 SCC 1 — Landmark case establishing: informed consent must be specific to the procedure; blanket consent is invalid; consent form must be read and explained; additional procedures without consent are malpractice; compensation for violation of consent rights is recoverable.

Indian Medical Association v. Patanjali Ayurved Ltd, 2024 INSC 605 — Addresses misleading health claims by companies.

Important Laws and Rules

Consumer Protection Act, 2019 — Medical services are covered as "service." Overcharging, malpractice, and deficiency of service are actionable.

Clinical Establishments Act, 2010 — Mandates standards for hospitals (hygiene, equipment, staff qualifications). Not uniformly enforced.

RTI Act, 2005 — Allows citizens to request information from government. Can be used to get government hospital statistics, complaint data, procedure rates.

Medical Negligence Standard — If a doctor didn't follow the standard of care that a reasonable doctor would have followed, that constitutes negligence, which is grounds for compensation.

APPENDIX D

Itemized Bill — What to Look For

When you receive a hospital bill, check each category carefully:

BED CHARGES

Should be standard rate per day. ICU bed should be 5–10x regular bed (not 20x). Multiple bed charges for same days is fraud.

SURGEON / DOCTOR FEES

Usually fixed per procedure. Multiple consultations by same doctor shouldn't be full fee each time.

MEDICATIONS

Generic cost should be 30–50% of branded. Quantity should match prescription. Check against pharmacy retail rates.

TESTS

Each test should be itemized separately. Check if test was actually done (get copies of reports). Check rates against standard lab prices.

"MISCELLANEOUS" CHARGES

Big red flag. Always ask for a breakdown. This is where padding is most often hidden.

NURSING / NURSING CARE

Standard rates apply. Multiple days of nursing charges should roughly scale with length of stay. "Advanced wound care" language for a basic dressing is inflation.

APPENDIX E

RTI Template — Hospital Data Request

To,
[Public Information Officer] [Name of Government Hospital] [Address]

Dear Sir/Madam,

Under the Right to Information Act, 2005, I request the following information:

1. What was the C-section rate for this hospital in [last 2 years]? (Provide monthly or yearly breakdown)

2. What was the hysterectomy rate (procedures per 1,000 women aged 30–50) in [last 2 years]?

3. How many patient complaints were received in [last year]? What action was taken on each?

4. What is the maternal mortality rate in this hospital for [last 2 years]?

5. What is the infant mortality rate in this hospital for [last 2 years]?

6. How many doctors are permanently employed vs. contract-based?

7. What is the infection rate for common procedures (C-section, appendectomy) in [last year]?

8. Copies of grievance redressal committee minutes for [last 6 months].

This information is in public interest and should be disclosed promptly. Yours faithfully,

[Your Name] [Your Address]
[Your Contact Number] [Date]

File this with the hospital's Public Information Officer. Allow 30 days for response. If not provided, appeal to the Appellate Authority.

APPENDIX F

Books and Resources to Read

— On Healthcare System

- *Dissenting Diagnosis* — Arun Gadre & Abhay Shukla (accounts of doctors on healthcare inequities in India)

- *The Healing Blade* — Atul Gawande (though focused on USA, the concepts and questions apply globally)

  Being Mortal — Atul Gawande (on end-of-life care and patient autonomy)

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On Patient Rights

Indian Constitution Article 21 (right to health)

- Consumer Protection Act, 2019 (full text available online)
- NMC Professional Conduct Regulations 2002

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On Healthcare Policy

NFHS-5 reports (nfhsindia.org) — detailed health statistics with state-level breakdowns

- National Health Mission reports (nhm.gov.in)
- Parliamentary Standing Committee reports on Health (rajyasabha.nic.in)

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APPENDIX G

Your Health Card — Keep This Safe

PERSONAL MEDICAL INFORMATION

My blood type: _____

My allergies: _____

My ongoing medications: _____

My chronic conditions: _____ My

emergency contact: _____

HEALTHCARE PROVIDERS I TRUST

Doctor name: _____ Contact: _____ Specialization: _____ Hospital name: _____ Contact: _____ Location: _____

DOCUMENTS I HAVE COPIES OF

Blood type certificate: Yes / No

Vaccine certificate: Yes / No

Medical records (discharge summaries, etc.): Yes / No Stored at: _____ Imaging (X-rays, CT, MRI): Yes / No Stored at: _____

INSURANCE INFORMATION

Policy number: _____ Insurer contact: _____ Network hospitals: _____ Helpline: _____

REGULATORY CONTACTS (FILL IN FOR YOUR DISTRICT)

District Medical Council: _____ District Consumer Forum: _____ PMJAY grievance: **14555**

National Consumer Helpline: **1915**

Police (women's help): **1090 or 100**